Understanding Basic Health

Basic Health is for Washington State residents who are:

- Not eligible for free or purchased Medicare
- Not institutionalized at the time of enrollment
- Within Basic Health's income guidelines

Cost

- Monthly premiums are based on age, income, family size, and health plan chosen
- No copayments for preventive care services
- Low copayments on some services
- $150 annual deductible
- 20% coinsurance on some services
- $1,500 annual out-of-pocket maximum

Choice of provider

- Select your own doctor or other provider affiliated with the health plan you choose
- Choice of health plans in most counties
- Decide on the health plan that offers the best value, location, and providers for you

Benefits

- Doctor and hospital care, including preventive care
- Emergency services
- Prescription drugs

Basic Health contracts with health plans all over Washington State to provide reduced-cost health care coverage to qualified Washington State residents. All health plans in Basic Health offer the same basic benefits, but monthly premiums, providers, and some details of coverage vary (such as which prescription drugs or preventive services are covered). The amount the state contributes to your monthly premium depends on:

- Your age;
- Your income;
- The number of people in your family; and
- The health plan you choose.

See the publication *Health Plans and Premiums* for more information about monthly premiums. Call 1-800-660-9840 if you need help with your estimate.

Basic Health™

Si desea ayuda en español, llame al 1-800-321-0291. Для обслуживания на русском языке, позвоните, пожалуйста, по телефону 1-800-387-8224.

한국어로 도움을 원하시면 1-800-324-1658로 연락하십시오. Nếu quý vị muốn được giúp bằng tiếng Việt, xin gọi số 1-800-423-2231.

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How it all works

Your monthly premium

Once enrolled in Basic Health, you'll get a bill for your monthly premium about six weeks before the month covered by that payment. (For example, the bill for December coverage is sent in mid-October; payment is due November 5.) Your monthly premium payment must always be received by the fifth of the month prior to the coverage month. If you do not pay your premiums when due, you will lose your coverage for at least one month, so it is important that you pay each monthly premium on time. Partial payment or checks that cannot be processed for any reason (for example, checks returned for non-sufficient funds or no signature) will be considered nonpayment.

Group applicants

If your employer, home care agency, or financial sponsor will be paying all or part of your monthly premium, Basic Health will bill them directly if you are approved and covered by that group. You may be required to contribute toward your monthly premium through payroll deductions or other methods. Contact your group representative for more information.

Cost-sharing responsibilities

Each Basic Health member is responsible for sharing the cost of his or her health care coverage. Cost sharing comes in the form of copays, coinsurance, and deductibles. In addition, each member will have an out-of-pocket maximum (as explained on page 3).

If a Basic Health member changes health plans any time during the year, the amount paid toward the deductible and out-of-pocket maximum for covered family members will start over with the new health plan.

These cost-sharing responsibilities do not affect coverage for Basic Health *Plus* or the Maternity Benefits Program.

Important!

Once you are enrolled in Basic Health, you need to let Basic Health know when you have any changes in family status or income. These changes may affect your monthly premium. If you do not keep your income information current, the state may require you to repay the state portion of your premium.

Definitions and examples

Copay

A set dollar amount you pay when receiving specific services or treatments. In most cases, this will be $15, except for prescription drugs and emergency room visits (see page 6). Copays do not apply to your deductible, coinsurance, or out-of-pocket maximum. The following are copays you will be responsible for in 2005:

Office visit:	$ 15
Prescription drugs	
Tier 1:	$ 10
Tier 2:	50% of the drug cost
Emergency room visit:	$100

How it works:
Sally takes her son, Charlie, to the pediatrician for a bad cough. Sally pays the $15 office visit copay at the doctor's office.

Deductible

The amount you pay before your health plan starts to pay for certain covered services. In 2005, you will be responsible for paying the first $150 of certain covered medical costs before your health plan pays 80% of the covered services. The $150 annual deductible must be met for each family member enrolled in Basic Health. The deductible does not apply towards the annual out-of-pocket maximum. If you change plans any time during the year, the amount you've paid toward your deductible for covered family members will start over with your new health plan.

How it works:
John falls off his roof and is taken to the hospital by ambulance. The ambulance service is subject to his annual deductible. John has not paid anything toward his deductible, so he is responsible for the first $150 of the $500 cost. He also is responsible for paying 20% coinsurance of the remaining bill.

AMBULANCE SERVICES:	$500
John's deductible:	$150
Remaining bill:	$350
John pays 20% of remaining bill:	$ 70
Health plan pays 80% of remaining bill:	$280
John's total cost:	$220

Because John has met his $150 deductible, he will only pay copayments and the 20% coinsurance for the rest of the year until he reaches his out-of-pocket maximum.

Coinsurance

The percentage you pay when your health plan pays less than 100% for covered services. Your health plan will not pay toward services with a coinsurance until you have paid your $150 annual deductible. In 2005, you will be responsible for paying 20% of the cost for services that have a coinsurance. Your health plan pays the remaining 80%.

How it works:
Sally is hospitalized for an injury. The hospital stay costs $1,000. The hospital stay is subject to her annual deductible. Sally has already paid her annual deductible, so she pays 20% coinsurance for the hospital stay and her health plan pays the remaining 80%.

HOSPITAL STAY:	$1,000
Sally pays 20%:	$ 200
Health plan pays 80%:	$ 800

Out-of-pocket maximum

Your coinsurance costs apply toward your out-of-pocket maximum of $1,500 per person, per calendar year. When you or another covered family member reaches the out-of-pocket maximum, you are not responsible for any further coinsurance costs for covered services received by that person during the year. Your health plan will pay 100% of all coinsurance costs. However, you will still be required to pay applicable copayments.

How it works:
When John fell off the roof, he seriously damaged his knee. He will need three surgeries in 2005 to repair the damage. Each surgery will cost $5,000 and his coinsurance is 20%. The surgeries are subject to his annual deductible, which he has already met with the ambulance service.

FIRST SURGERY:	$5,000
John pays 20%:	$1,000
Health plan pays 80%:	$4,000

For the second surgery, John will not have to pay the full 20% coinsurance because he has already paid $70 for the ambulance service and $1,000 for the first surgery, that go toward his annual out-of-pocket maximum of $1,500.

(continued on next page)

Definitions and examples (continued)

SECOND SURGERY:	$5,000
John pays:	$ 430 (the remainder of his $1,500 out-of-pocket maximum)
Health plan pays:	$4,570

As long as the third surgery occurs in 2005, John will not have to pay any deductible or coinsurance because he has already paid his out-of-pocket maximum with the ambulance service and the first two surgeries.

THIRD SURGERY:	$5,000
John pays:	$ 0
Health plan pays:	$5,000

John will still be responsible for paying his copays for follow-up office visits, prescription drugs, and for non-covered services.

Explanation of Benefits (EOB)

Each time you receive medical services, you will be sent a detailed statement from your health plan that explains which procedures and services were given, how much they cost, how much your plan pays, and how much you pay.

If you change health plans any time during the year, the amount you've paid toward your out-of-pocket maximum for covered family members will start over with your new health plan.

Children's coverage through Basic Health *Plus*

Basic Health *Plus* is a Medicaid program for children in qualified households. If you are eligible for Basic Health, your children may be eligible for Basic Health *Plus*. They must be under age 19 and U.S. citizens, or legal residents who arrived in the U.S. on or before August 22, 1996. If your children are not living in your household, you may be able to enroll them in Basic Health, but not Basic Health *Plus*.

The chart below lists the benefits for the two programs.

Basic Health benefits	**Basic Health *Plus* benefits**
No vision benefits	Vision benefits available
No dental benefits	Dental benefits available
Emergency transportation (ambulance) only	Non-emergency transportation to medical services
Waiting period for pre-existing conditions	No waiting period for pre-existing conditions
Deductible and coinsurance on some services	No deductible or coinsurance

Waiting periods

Pre-existing conditions

You must wait nine months from the day your coverage begins before Basic Health will cover pre-existing conditions, except for maternity care and prescription drugs.

If you had coverage similar to Basic Health coverage (including Healthy Options or other Medical Assistance program with similar coverage) any time in the three months just before you applied for or were enrolled in Basic Health, your waiting period for treatment of a pre-existing condition will be shorter. If your enrollment was delayed due to Basic Health enrollment limits, you may receive up to three months credit toward the waiting period. The table below gives examples of how this works.

Waiting period for organ transplant procedures

You must be enrolled in Basic Health for 12 consecutive months before you're covered for organ transplant procedures, unless:

- The transplant is for a condition that was not pre-existing; or
- The transplant is for a child enrolled in and continuously covered by Basic Health from the date of birth; or
- The transplant is for a child placed for adoption in the home of a Basic Health member within 60 days of birth and the child is continuously covered by Basic Health from the date of placement, if one or both of the adoptive parents were enrolled in Basic Health when the child was placed.

The waiting period for coverage of organ transplants will not be waived or reduced because of either:

- Other similar coverage in effect before your Basic Health enrollment; or
- Time spent waiting for Basic Health coverage.

Previous similar coverage	Months credited toward the nine-month waiting period for pre-existing conditions
Continuous coverage in effect within three months of either the date Basic Health receives your application or the date your coverage begins.	One month credit for each month of continuous coverage.
Coverage during both the three months before your application was received and the three months before your coverage begins, with a break in coverage.	One month credit for each month of continuous coverage during the longer of the two coverage periods. For example, if you had three months continuous coverage before your application date, and two months coverage before your Basic Health coverage began, credit would be given for three months coverage.

2005 Basic Health benefits and services

Benefits and services NOT subject to the deductible and coinsurance

The $150 annual deductible and $1,500 out-of-pocket maximum per person, per calendar year DO NOT apply to the following benefits and services.

Benefit/service	Member's payment responsibility	Notes
Preventive care	No copay	Includes routine physicals, immunizations, PAP tests, mammograms, and other screening and testing when provided as part of the preventive care visit.
Office visits	$15 copay	Copay is for office visit only and includes consultations, mental health and chemical dependency outpatient visits, office-based surgeries, and follow-up visits. Copays do not apply to preventive care, laboratory, radiology services, radiation, and chemotherapy. Some services will be subject to coinsurance.
Pharmacy*	 Tier 1 – $10 copay Tier 2 – 50% of the drug cost	30-day supply Tier 1 includes generic drugs in health plan's preferred drug list (formulary). Tier 2 includes brand-name drugs in health plan's preferred drug list (formulary).
Emergency room visit	$100 copay	No copay if admitted; hospital coinsurance and deductible would apply.
Out-of-area emergency services	$100 copay	No copay if admitted; hospital coinsurance and deductible would apply.
Urgent care	$15 copay	Copay is for office visit only, when provided in an urgent care setting. Deductible and coinsurance apply to all other services.
Skilled nursing, hospice, and home health care	No copay	Covered as an alternative to hospital care at the health plan's discretion.
Maternity care	No copay	If the member is eligible for the Maternity Benefits Program, maternity services can only be covered under Basic Health for 30 days following diagnosis of pregnancy. All other maternity services are covered through the Department of Social and Health Services.

*Different health plans have different lists of approved prescription drugs (formularies). To find out if a specific drug is covered in your pharmacy benefit, contact your health plan.

Benefits and services subject to the deductible and coinsurance

Before your health plan pays the 80% coinsurance for the following benefits, you must first pay your $150 annual deductible. Once you meet your $150 deductible, all coinsurance payments will be applied toward your $1,500 annual out-of-pocket maximum. Deductibles and out-of-pocket maximums are per person, per year. Once the $1,500 per person out-of-pocket maximum has been reached, the health plan pays for all covered benefits and services with a coinsurance. Members are only responsible for copays for benefits and services listed on page 6. If you change health plans any time during the year, the amount you've paid toward your deductible and out-of-pocket maximum for covered family members will start over with your new health plan.

Benefit/service	Member's payment responsibility	Description
Hospital, inpatient	20% coinsurance; deductible applies. $300 maximum facility charge per admittance.	Facility charges may include, but are not limited to, room and board, prescription drugs provided while an inpatient, and other services received as an inpatient. See "Other professional services" below.
Hospital, outpatient	20% coinsurance; deductible applies	
Other professional services	20% coinsurance; deductible applies	Includes services received as an inpatient, surgeries, anesthesia, chemotherapy, radiation, and other types of inpatient and outpatient services.
Mental health	20% coinsurance; deductible applies to inpatient. $300 maximum facility charge per admittance.	Limited to 10 inpatient days a year and 12 outpatient visits a year. Office visits to manage medication do not count towards 12-visit maximum. Outpatient visits are subject to $15 copay (see "Office visits").
Laboratory	No copay or coinsurance for outpatient services. 20% coinsurance for inpatient hospital-based laboratory services.	Deductible applies to services with coinsurance.
Radiology	20% coinsurance, except for outpatient x-ray and ultrasound.	Deductible applies to services with coinsurance.
Ambulance services	20% coinsurance; deductible applies	Includes approved transfers from one facility to another. No coinsurance if transfer is required by the health plan.
Chiropractic/physical therapy	20% coinsurance; deductible applies	Up to six visits combined for postoperative treatment following reconstructive joint surgery, as long as visits are within one year of surgery.
Chemical dependency	20% coinsurance and deductible apply to inpatient. $300 maximum facility charge per admittance.	Limited to $5,000 every 24-month period; $10,000 lifetime maximum. Outpatient visits are subject to $15 copay (see "Office visits").
Organ transplants	Deductible, coinsurance, and copays apply by specific service.	12-month waiting period, except for newborns or for a condition that is not pre-existing.

Basic Health exclusions

The services listed below are not covered:

1. Services that do not meet the Basic Health definition of "Medical Necessity" for the diagnosis, treatment, or prevention of injury or illness, or to improve the functioning of a malformed body member, even though such services are not specifically listed as exclusions.
2. Services not provided, ordered, or authorized by the member's health plan or its contracting providers, except in an emergency.
3. Services received before the member's effective date of coverage.
4. Custodial or domiciliary care, or rest cures for which facilities of an acute care general hospital are not medically required. Custodial care is care that does not require the regular services of trained medical or allied health care professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered.
5. Hospital charges for personal comfort items; or a private room unless authorized by the member's health plan; or services such as telephones, televisions, and guest trays.
6. Emergency facility services for nonemergency conditions.
7. Charges for missed appointments or for failure to provide timely notice for cancellation of appointments; charges for completing or copying forms or records.
8. Transportation except as specified under "Organ transplants" and "Emergency care."
9. Implants, except: cardiac devices, artificial joints, intraocular lenses (limited to the first intraocular lens following cataract surgery), and implants as defined in the "Plastic and reconstructive services" benefit.
10. Sex change operations.
11. Investigation of or treatment for infertility or impotence.
12. Reversal of sterilization.
13. Artificial insemination.
14. In-vitro fertilization.
15. Eyeglasses, contact lenses (except the first intraocular lens following cataract surgery); routine eye examinations, including eye refraction, except when provided as part of a routine examination under "Preventive care."
16. Hearing aids.
17. Orthopedic shoes and routine foot care.
18. Speech, occupational, and recreation therapy.
19. Medical equipment and supplies not specifically listed in the "Schedule of Benefits," except while the member is in the hospital (including, but not limited to, hospital beds, wheelchairs, and walk aids).
20. Dental services, including orthodontic appliances, and services for temporomandibular joint problems, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that such repair begins within ninety (90) days of the accidental injury or as soon thereafter as is medically feasible, and provided the member is eligible for covered services at the time that services are provided.
21. Medical services, drugs, supplies, or surgery directly related to the treatment of obesity, including morbid obesity (such as, but not limited to, gastroplasty, gastric stapling, or intestinal bypass).
22. Weight loss programs.
23. Cosmetic surgery, including treatment for complications of cosmetic surgery, except as otherwise provided in this "Schedule of Benefits."
24. Medical services received from or paid for by the Veterans Administration or by state or local government, except where in conflict with Washington State or federal law or regulation; or the portion of expenses for medical services payable under the terms of any insurance policy that provides payment toward the member's medical expenses without a determination of liability to the extent that payment would result in double recovery.
25. Conditions resulting from acts of war (declared or not).
26. Direct complications arising from excluded services.
27. Replacement of lost or stolen medications.
28. Evaluation and treatment of learning disabilities, including dyslexia.
29. Any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracting provider and authorized in advance by the health plan.

Maternity services

How it works

Basic Health members who are pregnant usually receive care through the Maternity Benefits Program (a Medicaid program). This program, jointly administered by Basic Health and Department of Social and Health Services (DSHS), allows you to receive maternity benefits through the same health plan you choose for Basic Health. When selecting a provider for your maternity services, make sure (s)he contracts with your chosen health plan.

More services

The Maternity Benefits Program allows you to receive other services called First Steps, which include maternity support, such as:

- Child-birth education classes,
- Child care, and
- Transportation to medical appointments.

Eligibility

If you are pregnant when you apply for Basic Health, your application will be referred to DSHS to determine your eligibility for the Maternity Benefits Program. If you want to be enrolled in Basic Health while your eligibility for the Maternity Benefits Program is being determined, you must specifically request that on your application. If you do not qualify for the Maternity Benefits Program, you may be able to receive maternity services through Basic Health.

If you are pregnant and your income is higher than Basic Health's income guidelines, go to your local DSHS Community Service Office to apply for the Maternity Benefits Program. DSHS determines eligibility for the Maternity Benefits Program based on Medicaid eligibility criteria. There are some differences between Medicaid and Basic Health eligibility criteria. For example, Medicaid criteria will count your unborn child when determining your family size, while Basic Health does not count the child until birth. As a result, you may be eligible for one program, but not the other.

How to apply

You can request a *Maternity Benefits Application* and other materials from Basic Health. Medicaid requires written verification of the pregnancy from a licensed doctor, nurse, or medical lab, and will ask for an estimated due date. Home pregnancy tests are not accepted as proof of pregnancy. If you are eligible for the Maternity Benefits Program, Basic Health will cover maternity services for only 30 days after your doctor verifies your pregnancy. To continue your maternity coverage without interruption, Basic Health must receive your Maternity Benefits Application within 30 days of the date your pregnancy is verified. If you do not apply within that time, you'll have to pay the full cost of any maternity care you receive beyond 30 days after your pregnancy is verified.

When coverage begins

Coverage for maternity services will begin only when your Basic Health coverage begins. (If you're eligible, DSHS may provide other assistance for maternity services received during the most recent three months before your Basic Health coverage starts.)

Please note:

2005 benefit changes affect Basic Health members, not Basic Health *Plus* or Maternity Benefits Program members.

How the health plans work

The health plans require each Basic Health member to select a primary care provider (PCP). To receive benefits, you must receive care from your health plan's authorized providers. Your PCP may provide or coordinate your care. Each covered family member may have a different PCP. If you don't choose a PCP, your health plan may choose one for you. You may change your PCP during the year. Contact the health plan for more information on changing a PCP or for a current list of providers.

In an emergency, you may receive Basic Health benefits for care without prior PCP approval.

However, you must report this to your primary care provider or health plan within 24 hours or as soon as possible. In addition, women may self-refer to a plan-designated women's health care professional for medically necessary services or medically appropriate follow-up for maternity care, routine gynecological exams, and reproductive care. Check with your health plan for details.

Any care not approved by your health plan is not covered under Basic Health. If you receive care that is not covered under Basic Health, you must pay the entire cost for those services.

Choosing a health plan

Think about the following things when choosing a health plan. If you have questions or need specific information, call the health plan directly.

- **Benefits**

  All health plans in Basic Health offer the same basic benefits, but monthly premiums, providers, and some details of coverage may vary (such as which prescription drugs or preventive services are covered).

- **Doctors or other providers**

  Be sure to consider your choice of providers (doctors, clinics, hospitals, pharmacies, and other health care professionals) as well as monthly premium. Your current provider, or the providers nearest to you, may not contract with the lowest-cost health plan.

  If you have Internet access, visit our Web site at **www.basichealth.hca.wa.gov** or the health plans' Web sites (listed on page 11) for provider listings. If you have a specific provider you would like to see, ask if (s)he will be participating with Basic Health and the health plan you've chosen in 2005. You should also confirm this with the health plan.

- **Provider groups**

  Some health plans may contract with provider groups, called subnetworks; this may limit your choice of providers. You may be required to see specialists or use facilities, such as hospitals, which are in the same subnetwork as your PCP. This means that even if a provider is listed with your health plan, the provider's services may not be available to you unless the provider is also affiliated with your PCP. Call the health plan or your PCP to find out if your PCP can refer you to anyone listed as a provider with that health plan, or if your PCP can refer you to only a selected group of providers within the health plan.

- **Prescription drugs**

  If you take medications regularly, ask the health plan if it covers those prescriptions. Health plans do not all cover the same prescriptions.

For application questions

Basic Health's (Health Care Authority) Web site ..... **www.basichealth.hca.wa.gov**
(Includes provider directory, *Member Handbook*, and other useful information)

For additional information, call Basic Health 1-800-660-9840

For health plan information

Health plan information in this document is believed to be accurate and current, but be sure to confirm with the health plan before making decisions.

	Customer service hours	Customer service phone numbers	Web site address
Columbia United Providers, Inc.	Mon. – Fri. 8 a.m. – 5 p.m.	1-800-315-7862 or 360-891-1520 TDD: 1-866-287-9962	www.cuphealth.com
Community Health Plan of Washington	Mon. – Fri. 8 a.m. – 6 p.m.	1-800-440-1561 TTY/TDD: 1-800-833-6388	www.chpw.org
Group Health Cooperative	Mon. – Fri. 8 a.m. – 5 p.m.	1-888-901-4636 TTY: 1-800-833-6388	www.ghc.org
Kaiser Foundation Health Plan of the Northwest	Mon. – Fri. 8 a.m. – 6 p.m.	1-800-813-2000 TTY: 1-800-735-2900	www.kp.org
Molina Healthcare of Washington, Inc.	Mon. – Fri. 7:30 a.m. – 6 p.m.	1-800-869-7165 TTY: 1-877-665-4629	www.molinahealthcare.com

After you send in a Basic Health application

Basic Health receives many applications, and processes them on a first-come, first-served basis. "Processing" means that a Basic Health staff member will review your application and any documentation you sent with it. If you are eligible and there is space available, we will then send you a bill for your first month's premium; this bill will tell you when your Basic Health coverage will begin, as long as your payment is received by the due date.

If you are enrolling in Basic Health, the health plan you choose will send identification (I.D.) cards for you and your enrolled family members. Some health plans may require that you choose a primary care provider before they will issue your I.D. card. The enrollment confirmation letter you receive from Basic Health can serve as temporary identification until you receive your card.

It is important to remember that Basic Health is a state program; we use tax dollars to help pay for your health coverage. Because of this, it is important that we frequently verify eligibility of Basic Health members. At least once each year, Basic Health will ask you for updated documentation to verify your eligibility; this may include proof of income, residency, and family size. To ensure your continued enrollment in the program, you must respond to any requests for information completely and by the due date given at that time. This process is called "recertification."

On an ongoing basis, you are responsible for letting us know if any of the information used to verify your eligibility for Basic Health changes. You will receive a *Basic Health Member Handbook* when you enroll; it will explain the details. If you have questions, please visit our Web site at **www.basichealth.hca.wa.gov**, or call 1-800-660-9840.

Basic Health™

www.basichealth.hca.wa.gov

To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.